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June 13, 2017

WC: 02-60

Accepted / Filed

JUL 13 2017

Federal Communications Commission
Office of the Secretary

DOCKET FILE COPY ORIGINAL

Sent Via Hand Delivery and Email
Ajit Pai, Chairman
Federal Communications Commission
445 12th Street SW
Washington, DC 20554
Email: ajit.pai@fcc.gov

RE: USAC Funding Cap for 2016 Funding

Dear Mr. Pai,

Our law firm represents Indian Tribes and tribal health organizations throughout the United States. Yesterday, we filed, on behalf of five Tribal health organizations in Alaska, appeals from decisions made under the FCC Rural Health Care (RHC) program to deny funding based upon the exhaustion of 2016 funds in the $400 million cap. Those appeals through the RHC process involve the Aleutian/Pribilof Island Association, the Norton Sound Health Corporation, the Bristol Bay Area Health Corporation, the Maniilaq Association, and the Council of Athabascan Tribal Governments.

In each case, these organizations were substantially impacted by this loss of 2016 funding—close to $3 million in aggregate. When Congress authorized the creation of the RHC program, it did not create or mandate a cap. Rather, Congress mandated that rural health care providers be given the opportunity to access internet and telecommunications services on the basis of their urban peers and stated unequivocally that the telecommunications providers had a right and were entitled to payment.

While these appeals will run its course through the RHC/USAC process, I wanted to bring it to your attention given the substantial tribal impact and since you will be interacting with representatives from some of these organizations tomorrow at the NCAI Mid-Year Conference and this issue will come up.

Thank you for your consideration of these issues and I look forward to meeting you soon.

Sincerely,

HOBBS, STRAUS, DEAN & WALKER, LLP

By: _____
Geoff Strommer

cc: Dimitri Philemonof, President/CEO, APIA
Robert J. Clark, President/CEO, BBAHC
Debra McCarty, Interim Executive Director, CATG
Tim Gilbert, President/CEO, Maniilaq Association
Angie Gorn, President/CEO, NSHC

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Letter of Appeal
Rural Health Care Division
Universal Service Administrative Company
2000 L Street, N.W., Suite 200
Washington, D.C. 20036

Appellant/Health Care Provider:	Bristol Bay Area Health Corporation 6000 Kanakanak Road Dillingham, AK 99576 (907) 842-5201 HCP No. (see Table 1 below)
Service Provider Name:	GCI Communication Corp. SPIN 143001199
Form 465 Number:	(see Table 1 Below)
Funding Request Number:	(see Table 1 Below)

Dear Rural Health Care Division Staff:

Bristol Bay Area Health Corporation (BBAHC) provides health care services to Alaska Natives and other beneficiaries on behalf of tribal governments and Native Villages in the Bristol Bay region pursuant to the Alaska Tribal Health Compact and funding agreements with the Secretary of Health and Human Services under the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 et seq. BBAHC hereby requests review and reversal of the decision of the Rural Health Care (RHC) Division to deny funding for the above-referenced Funding Requests for services provided by GCI.[1]

BBAHC believes that the RHC Division erred in concluding that it would arbitrarily apply an across-the-board pro rata reduction in funding due to the $400 million funding cap that the Federal Communications Commission (FCC) purported to impose, thus eliminating any opportunity for full funding for the services requested in its Forms 465 and Form 466. Therefore, BBAHC believes that it has met all requirements of the RHC funding mechanism, and that the RHC Division should have committed funding for the Funding Requests summarized in the attached table.

Background

The BBAHC Form(s) 465 referenced in the below Table 1 were submitted on behalf of BBAHC for services at clinics that provide health care for BBAHC member tribes' populations as well as other eligible beneficiaries.

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[1] RHC Division Funding Commitment Letters dated April 11, 2017 attached as **Exhibit A.**

On April 11, 2017, 55 Funding Commitment Letters (FCLs) were issued by USAC. In those FCLs, USAC for the first time distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The asterisk used by USAC then stated the following: "The pro-rata factor for this filing window period is 92.52804%."

USAC remitted funding to BBAHC through the FCLs at the rate of 92.52804% of the amount requested, resulting in the denial of funding for the FCLs in the amount of $1,757,574.99. The application of a pro rata percentage of funding by USAC amounted to a partial denial of funding, even though the FCL is not written by USAC as a funding denial.

BBAHC believes that its funding request and the total funding amount approved by USAC comply with applicable law and the FCC's requirements, but that the arbitrarily created category of "Committed Funding" based upon a pro rata formula is contrary to applicable law and policy. Therefore, BBAHC respectfully requests that the RHC Division reverse its decision and issue full funding for these funding requests.

Requested and Disputed Funding

The table below lays out in detail the Service Provider, Health Care Provider, Form 465 Application Numbers, Funding Request Numbers, total funding requested and approved by USAC, as well as the total "Committed Funding Amount" by USAC, which reflects the application of the pro rata formula.

Table 1

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI - 143001199	Chignik Lake Clinic 10973	43162386	16881531	$157,657.35	$145,877.26	$11,780.09
GCI - 143001199	Chignik Lake Clinic 10973	43162386	16885661	$89,159.66	$82,497.69	$6,661.97
GCI - 143001199	Chignik Lake Clinic 10973	43162386	16901981	$638,750.39	$591,023.22	$47,727.17
GCI - 143001199	Clarks Point Health Clinic 10974	43162387	16885711	$1,202.21	$1,112.38	$89.83
GCI - 143001199	Clarks Point Health Clinic	43162387	16902691	$7,841.16	$7,255.27	$585.89

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
	10974					
GCI - 143001199	Naknek Clinic 10975	43162388	16885721	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	Naknek Clinic 10975	43162388	16902701	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	New Stuyahok Clinic 10976	43162389	16885741	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	New Stuyahok Clinic 10976	43162389	16902741	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Perryville Clinic 10980	43162390	16885761	$157,657.35	$145,877.26	$11,780.09
GCI - 143001199	Perryville Clinic 10980	43162390	16885771	$89,159.66	$82,497.69	$6,661.97
GCI - 143001199	Perryville Clinic 10980	43162390	16902791	$638,750.39	$591,023.22	$47,727.17
GCI - 143001199	Aleknagik Health Clinic 10981	43162391	16885801	$1,202.21	$1,112.38	$89.83
GCI - 143001199	Aleknagik Health Clinic 10981	43162391	16902821	$7,841.16	$7,255.27	$585.89
GCI - 143001199	Chignik Bay Subregional Clinic 10982	43162392	16885811	$159,459.26	$147,544.53	$11,914.73
GCI - 143001199	Chignik Bay Subregional Clinic 10982	43162392	16885821	$90,178.69	$83,440.57	$6,738.12
GCI – 143001199	Chignik Bay	43162392	16902841	$632,265.22	$585,022.62	$47,242.60

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
	Subregional Clinic 10982					
GCI - 143001199	Chignik Lagoon Clinic 10983	43162393	16885831	$159,459.26	$147,544.53	$11,914.73
GCI – 143001199	Chignik Lagoon Clinic 10983	43162393	16885851	$90,178.69	$83,440.57	$6,738.12
GCI - 143001199	Chignik Lagoon Clinic 10983	43162393	16902861	$632,265.22	$585,022.62	$47,242.60
GCI - 143001199	King Salmon Health Clinic 10989	43162394	16885911	$195,202.28	$180,616.84	$14,585.44
GCI - 143001199	King Salmon Health Clinic 10989	43162394	16903001	$576,375.80	$533,309.23	$43,066.57
GCI - 143001199	Platinum Clinic 10990	43162395	16885941	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	Platinum Clinic 10990	43162395	16902871	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Port Heiden Clinic 10991	43162396	16886031	$159,459.26	$147,544.53	$11,914.73
GCI - 143001199	Port Heiden Clinic 10991	43162396	16886061	$90,178.69	$83,440.57	$6,738.12
GCI - 143001199	Port Heiden Clinic 10991	43162396	16902901	$632,265.22	$585,022.62	$47,242.60
GCI -	Kanakanak	43162397	16886131	$81,759.61	$75,650.56	$6,109.05

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
143001199	Hospital 10992					
GCI - 143001199	Kanakanak Hospital 10992	43162397	16886201	$1,077,512.77	$997,001.45	$80,511.32
GCI - 143001199	Kanakanak Hospital 10992	43162397	16886241	$47,382.00	$43,841.64	$3,540.36
GCI - 143001199	Kanakanak Hospital 10992	43162397	16903921	$4,014,912.31	$3,714,919.67	$299,992.64
GCI - 143001199	Kanakanak Hospital 10992	43162397	16903961	$1,076,895.00	$996,429.84	$80,465.16
GCI - 143001199	Pilot Point Clinic 10993	43162398	16886381	$159,459.26	$147,544.53	$11,914.73
GCI - 143001199	Pilot Point Clinic 10993	43162398	16886411	$90,178.69	$83,440.57	$6,738.12
GCI - 143001199	Pilot Point Clinic 10993	43162398	16902931	$632,265.22	$585,022.62	$47,242.60
GCI - 143001199	Egegik Clinic 10994	43162399	16886451	$157,657.35	$145,877.26	$11,780.09
GCI - 143001199	Egegik Clinic 10994	43162399	16886491	$89,159.66	$82,497.69	$6,661.97
GCI - 143001199	Egegik Clinic 10994	43162399	16903021	$638,750.39	$591,023.22	$47,727.17
GCI - 143001199	Ekwok Health Clinic 10995	43162420	16886531	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	Ekwok Health Clinic 10995	43162420	16903041	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Levelock Health Clinic 10996	43162421	16886541	$60,039.68	$55,553.54	$4,486.14

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI - 143001199	Levelock Health Clinic 10996	43162421	16903081	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	South Naknek Clinic 10998	43162422	16886551	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	South Naknek Clinic 10998	43162422	16903091	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Twin Hills Clinic 10999	43162423	16886561	$158,153.34	$146,336.19	$11,817.15
GCI - 143001199	Twin Hills Clinic 10999	43162423	16903101	$783,679.83	$725,123.59	$58,556.24
GCI - 143001199	Manokotak Clinic 11005	43162424	16886571	$1,387.16	$1,283.51	$103.65
GCI - 143001199	Manokotak Clinic 11005	43162424	16903111	$7,373.03	$6,822.12	$550.91
GCI - 143001199	Goodnews Bay Clinic 11007	43162425	16886581	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	Goodnews Bay Clinic 11007	43162425	16903151	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Togiak Subregional Clinic 11008	43162426	16886591	$142,045.07	$131,431.52	$10,613.55
GCI - 143001199	Togiak Subregional Clinic 11008	43162426	16903171	$816,333.27	$755,337.17	$60,996.10
GCI - 143001199	Koliganek Clinic 11009	43162427	16886601	$60,039.68	$55,553.54	$4,486.14
GCI -	Koliganek	43162427	16903181	$982,568.22	$909,151.12	$73,417.10

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
143001199	Clinic 11009					
					Total:	**$1,757,574.99**

Discussion

The BBAHC is not merely an interest group, community health program, or loose assemblage of health care providers in rural Alaska. BBAHC is a regional organization formed by sovereign Alaska Native nations, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by BBAHC in the Bristol Bay region is not simply a goal to hopefully be obtained but is rather a part of the federal trust responsibility to tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of America, the Supreme Court ruled on several aspects of what has become known as "federal Indian law," including the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.*

The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" took different forms and doctrines. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care with the Indian Health Care Improvement Act, where the federal government found that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting

responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

It is against this backdrop of the federal trust responsibility to provide health care services to tribes and Alaska Native villages that the FCC's approach to rural health care must be understood. The FCC took up the matter of its own relationship with tribes/Alaska Natives in June 2000 with its Policy Statement "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes." In that Policy Statement, the FCC states that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

Among other ways that the FCC has specifically committed itself to implementing the trust responsibility, the FCC states that it will "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives ... that Indian Tribes have adequate access to communications services." *Id.* at 4. The FCC also, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* In addition, the FCC "[w]ill endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

The BBAHC has entered into multiple agreements with the federal government under the Indian Self-Determination and Education Assistance Act (ISDEAA) in order to contract/compact for funding to carry out health care programs, functions, services and activities. Health care is one such area where BBAHC, and its member tribes and villages, fundamentally rely upon RHC funding through the USAC to carry out federal programs and the federal trust responsibilities. Therefore, BBAHC relies upon the FCC to implement federal law and regulations related to RHC funding and implementation in a manner that is supportive of the trust responsibility as well as the contractual obligations between BBAHC and the United States.

Section 254(h)(1)(A) of the Telecommunications Act is written unambiguously as a mandatory program that includes funding as an entitlement associated with that mandate. Under Section 254(h)(1)(A), Congress instructed the FCC to make payments to telecommunications providers on behalf of rural health care providers and a "[t]elecommunications carrier providing service under this paragraph **shall be entitled** to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its **obligation** to participate in the mechanisms to

preserve and advance universal service." (emphasis added) 47 U.S.C. § 254(h)(1)(A). Like the federal trust responsibility, these payments by the FCC, through the USAC, are mandatory, not optional. The FCC and the USAC may not ignore the mandatory language of the statute by invoking a non-statutory cap on payments.[2]

If the RHC has a question with how to interpret the meaning of "shall be entitled" and "obligation", it should note that the Commission has, in the past, interpreted other terms in question in favor of federally recognized tribes "[i]n light of the goal of the rural health care universal service provision...and consistent with the federal trust relationship between the federal government and federally-recognized Indian tribes" such as the BBAHC's member tribes. *FCC Order in the Matter of Requests for Review of the Decisions of the Universal Service Administrator by Kawerak, et. al.*, 18 FCC Rcd. 18767 (2003).

Following the passage of the Telecomm Act in 1997, and during the implementation phase of the RHC funding, the FCC issued a Report and Order "In the Matter of Federal-State Joint Board on Universal Service" (hereafter "*FCC Universal Service Order*"), FCC Docket No. 96-45 (May 8, 1997). In the Order, the FCC agreed that the RHC funding was not a discretionary grant program, but involved the right to federal funding:

> Section 254(h)(1)(A) grants the **right to receive** federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state." *FCC Universal Service Order* at 335-36 (emphasis added).

But instead of then structuring the program at the outset as a program with mandatory funding obligations that sprang from the statute itself, the FCC made the determination to establish a $400 million cap on RHC funding. It did so not because it was directed to by Congress, or because the initial Joint Board suggested a cap, but instead to "be specific, predictable, and sufficient." *FCC Universal Service Order* at 365.

FCC lacked the authority, under the statute, to create this arbitrary cap. The legality of the cap has not yet been litigated because the funding within the so-called cap has, until 2016, kept pace with demand for funding. This is notwithstanding the fact that if the initial $400 million cap had been increased in pace with inflation, it should now (at a minimum) be funded at $609,405,607. Nonetheless, the FCC has kept the cap in place, despite the mandate of the statute.

Even when it established the cap, the FCC still intended the RHC to provide full funding. In the FCC Universal Service Order, the FCC found that the cap was only intended to provide a

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[2] *Cf. Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012) (statute requires full payment of tribal organization's "contract support costs" despite spending caps). In *Ramah*, the caps were statutory, and full payment was still required. Here, the caps are merely unpromulgated agency guidelines.

specific amount to Congress, not to require a pro rata formula for distribution. The FCC stated "[w]e estimate that the **maximum** cost of providing services eligible for support under section 254(h)(1)(A) is $366 million, if **all eligible health care providers** obtain the **maximum** amount of supported services to which they are **entitled**." *FCC Universal Service Order* at 366 (emphasis added).

Funding for broadband-enabled health care is needed today more than ever, and the $400 million cap established 20 years ago was not established consistent with the statutory language mandating full RHC funding. The USAC now administers almost $10 billion annually in the Universal Service Fund.[3] The FCC cap, in shorting tribes and Alaska Native organizations such as BBAHC, has violated the agency's own tribal Policy Statement as well as the trust responsibility of the federal government to provide health care to American Indians/Alaska Natives. 2016 has shown that this arbitrary cap is now not only no longer sufficient to meet burgeoning demand, but the inclusion of a new class of provider eligible to receive funding – skilled nursing facilities – beginning in 2017 will place additional demands on funding and further erode BBAHC programs and services. Lives are truly at stake.

Conclusion

Therefore, for the foregoing reasons, BBAHC requests that this appeal be granted and that the RHC Division commit full funding for all of the attached FCLs in the amount that is in dispute due to the pro rata formula $1,757,574.99.

Respectfully Submitted,

Geoffrey D. Strommer by SDO

Geoffrey D. Strommer
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On behalf of
Bristol Bay Area Health Corporation

[3] http://www.usac.org/about/default.aspx.

Bristol Bay Area Health Corporation
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www.bbahc.org

Bristol Bay Area Health Corporation is a tribal organization representing 28 villages in Southwest Alaska:

- Aleknagik
- Chignik Bay
- Chignik Lagoon
- Chignik Lake
- Clark's Point
- Dillingham
- Egegik
- Ekuk
- Ekwok
- Goodnews Bay
- Ivanof Bay
- Kanatak
- King Salmon
- Knugank
- Koliganek
- Levelock
- Manokotak
- Naknek
- New Stuyahok
- Perryville
- Pilot Point
- Platinum
- Port Heiden
- Portage Creek
- South Naknek
- Togiak
- Twin Hills
- Ugashik

Our mission is to provide quality health care with competence and sensitivity

May 24, 2017

Chairman Ajit Pai
Commissioner Mignon Clyburn
Commissioner Michael O'Rielly
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

RE: Rural Health Care Universal Services Support, WC Docket No. 02-60, Actions to Accelerate Broadband-Enabled Health Care Solutions, GN Docket No 16-46

Dear Chairman Pai and FCC Commissioners:

I am writing to ask for your support to ensure that Alaskans continue to have access to affordable broadband tele-health services in rural and tribal communities. We ask that you take steps to ensure both the near and long-term viability of the Rural Health Care Program to meet the increased demand for telemedicine services both in Alaska and across the nation.

Background

The Bristol Bay Area Health Corporation (BBAHC) was created in 1973 to provide health care services to the Alaska Native people of Southwest Alaska. We began operating and managing the Kanakanak Hospital and the Bristol Bay Service Unit for the Indian Health Service (IHS) in 1980, and were the first tribal organization to do so under the Indian Self-Determination and Education Assistance Act (ISDEAA). BBAHC is now responsible for and successfully providing and promoting health care to 28 Alaska Native Villages.

For many years the BBAHC has been a recipient of the Rural Health Care (RHC) Universal Service Support, specifically under the Telecommunications Program. These program funds have been key for our organization to deploy and use telehealth tools supporting high speed broadband that has become a platform for 21st Century Electronic Health Records that can be shared securely with other medical providers to directly improve patient care throughout Alaska. In addition, the support helps us to alleviate the high costs of transportation associated with travel to and from rural Alaska. The proposal by the FCC to pro-rate subsidies for Internet service is a potentially devastating development that would undermine BBAHC's ability to provide adequate health care services to our tribal communities.

Devastating Impacts

We were informed by the USAC Rural Health Care Program that because the total dollar value of all qualifying funding requests received by the close of the second filing window period ($274,725,249) exceeded the RHC Program funding available ($254,255,017) at the beginning of the filing window period, all qualifying funding requests will receive a pro-rated percentage of the qualifying funding requested; a reduction of 7.5%.

BBAHC will be significantly impacted by this reduction in funding and as a result will likely have to reduce or interrupt the broadband services currently used that allow us to provide healthcare. The outcome is likely to be a substantial reduction in patient health care services, which could adversely affect the lives of thousands of Alaskans.

BBAHC is very concerned that if funding requests are reduced (pro-rated) or denied entirely, the continuity of our existing and new rural health care services will be put in immediate jeopardy. Our health organization currently receives a subsidy from the Universal Administrative Company (USAC) that offsets our Internet expenses so we are able to connect through satellite. Our current payment is $94,000 per month. Under the FCC proposal our payments would increase to $175,000 per month. In other words, an annual increase of $2.72 million.

The BBAHC is not able to pay for such a substantial increase for the cost of Internet connectivity. This increase will affect not only our health organization, but would negatively impact the entire Alaska Tribal Health System in the State of Alaska. Connectivity is the lifeline for health services in our state where a majority or rural communities are not connected to a road system. BBAHC serves a vast area covering 28 tribal villages and currently has a USAC Internet subsidy to allow the organization to connect through satellite.

Improve Rural Healthcare Services

Telemedicine has allowed our tribal health organization to dramatically improve access to care, accelerate diagnosis and treatment, avoid unnecessary emergency transportation, expand local treatment options, and help to reduce Medicaid costs. Our health facilities are not able to raise service rates to compensate for the increase in costs to cover the proposed pro-ration.

We believe that the FCC should increase the budget for the rural health care support mechanisms to reflect inflation over the past two decades. Please urge the FCC to increase the Rural Health Care Universal Service Support budget, index it for inflation, and provide for any unused funds to be carried forward to future funding years.

Thank you for your consideration and attention to this urgent matter.

Respectfully,

Robert J. Clark, President & CEO

CC:
The Honorable Senator Murkowski
The Honorable Senator Sullivan
The Honorable Congressman Young

Letter of Appeal
Rural Health Care Division
Universal Service Administrative Company
2000 L Street, N.W., Suite 200
Washington, D.C. 20036

Appellant/Health Care Provider:	Council of Athabascan Tribal Governments P.O. Box 33 Fort Yukon, AK 99740 Tel: 907-662-2587 HCP No. (see Table 1 below)
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Funding Request Number:	(see Table 1 Below)

Dear Rural Health Care Division Staff:

The Council of Athabascan Tribal Governments (CATG) is a tribal consortium representing ten Gwich'in and Koyukon Athabascan villages in the Yukon Flats region of Alaska. CATG provides health care services to Alaska Natives and other beneficiaries on behalf of ten federally recognized tribal governments pursuant to the Alaska Tribal Health Compact and funding agreements with the Secretary of Health and Human Services under the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 et seq. CATG hereby requests review and reversal of the decision of the Rural Health Care (RHC) Division to deny funding for the above-referenced Funding Requests for services provided by GCI.[1]

CATG believes that the RHC Division erred in concluding that it would arbitrarily apply an across-the-board pro rata reduction in funding due to the $400 million funding cap that the Federal Communications Commission (FCC) purported to impose, thus eliminating any opportunity for full funding for the services requested in its Forms 465 and Form 466. Therefore, CATG believes that it has met all requirements of the RHC funding mechanism, and that the RHC Division should have committed funding for the Funding Requests summarized in the attached table.

Background

The CATG Form(s) 465 referenced in the below Table 1 were submitted on behalf of CATG for services at clinics that provide health care for CATG member tribes' populations as well as other eligible beneficiaries.

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[1] RHC Division Funding Commitment Letters dated April 11, 2017 attached as **Exhibit A.**

On April 11, 2017, a Funding Commitment Letter (FCL) was issued by USAC. In this FCL, USAC for the first time distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The asterisk used by USAC then stated the following: "The pro-rata factor for this filing window period is 92.52804%."

USAC remitted funding to CATG through the FCL at the rate of 92.52804% of the amount requested, resulting in the denial of funding for the FCL in the amount of $8,434.74. The application of a pro rata percentage of funding by USAC amounted to a partial denial of funding, even though the FCL is not written by USAC as a funding denial.

CATG believes that its funding request and the total funding amount approved by USAC comply with applicable law and the FCC's requirements, but that the arbitrarily created category of "Committed Funding" based upon a pro rata formula is contrary to applicable law and policy. Therefore, CATG respectfully requests that the RHC Division reverse its decision and issue full funding for these funding requests.

Requested and Disputed Funding

The table below lays out in detail the Service Provider, Health Care Provider, Form 465 Application Numbers, Funding Request Numbers, total funding requested and approved by USAC, as well as the total "Committed Funding Amount" by USAC, which reflects the application of the pro rata formula.

Table 1

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI 143001199	Arctic Village Clinic 11018	43125521	16902011	$112,885.20	$104,450.46	$8,434.74

Discussion

The CATG is not merely an interest group, community health program, or loose assemblage of health care providers in rural Alaska. CATG is a regional organization formed by sovereign Alaska Native nations, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by CATG is not simply a goal to hopefully be obtained but is rather a part of the federal trust responsibility to tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of America, the Supreme Court ruled on several aspects of what has become known as "federal

Indian law," including the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.*

The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" took different forms and doctrines. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care with the Indian Health Care Improvement Act, where the federal government found that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

It is against this backdrop of the federal trust responsibility to provide health care services to tribes and Alaska Native villages that the FCC's approach to rural health care must be understood. The FCC took up the matter of its own relationship with tribes/Alaska Natives in June 2000 with its Policy Statement "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes." In that Policy Statement, the FCC states that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

Among other ways that the FCC has specifically committed itself to implementing the trust responsibility, the FCC states that it will "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives ...that Indian Tribes have adequate access to communications services." *Id.* at 4. The FCC also, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to

implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* In addition, the FCC "[w]ill endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

The CATG has entered into multiple agreements with the federal government under the Indian Self-Determination and Education Assistance Act (ISDEAA) in order to contract/compact for funding to carry out health care programs, functions, services and activities. Health care is one such area where CATG, and its member tribes and villages, fundamentally rely upon RHC funding through the USAC to carry out federal programs and the federal trust responsibilities. Therefore, CATG relies upon the FCC to implement federal law and regulations related to RHC funding and implementation in a manner that is supportive of the trust responsibility as well as the contractual obligations between CATG and the United States.

Section 254(h)(1)(A) of the Telecommunications Act is written unambiguously as a mandatory program that includes funding as an entitlement associated with that mandate. Under Section 254(h)(1)(A), Congress instructed the FCC to make payments to telecommunications providers on behalf of rural health care providers and a "[t]elecommunications carrier providing service under this paragraph **shall be entitled** to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its **obligation** to participate in the mechanisms to preserve and advance universal service." (emphasis added) 47 U.S.C. § 254(h)(1)(A). Like the federal trust responsibility, these payments by the FCC, through the USAC, are mandatory, not optional. The FCC and the USAC may not ignore the mandatory language of the statute by invoking a non-statutory cap on payments.[2]

If the RHC has a question with how to interpret the meaning of "shall be entitled" and "obligation", it should note that the Commission has, in the past, interpreted other terms in question in favor of federally recognized tribes "[i]n light of the goal of the rural health care universal service provision...and consistent with the federal trust relationship between the federal government and federally-recognized Indian tribes" such as the CATG's member tribes. *FCC Order in the Matter of Requests for Review of the Decisions of the Universal Service Administrator by Kawerak, et. al.*, 18 FCC Rcd. 18767 (2003).

Following the passage of the Telecomm Act in 1997, and during the implementation phase of the RHC funding, the FCC issued a Report and Order "In the Matter of Federal-State Joint Board on Universal Service" (hereafter "*FCC Universal Service Order*"), FCC Docket No.

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[2] *Cf. Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012) (statute requires full payment of tribal organization's "contract support costs" despite spending caps). In *Ramah*, the caps were statutory, and full payment was still required. Here, the caps are merely unpromulgated agency guidelines.

96-45 (May 8, 1997). In the Order, the FCC agreed that the RHC funding was not a discretionary grant program, but involved the right to federal funding:

> Section 254(h)(1)(A) grants the **right to receive** federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state." *FCC Universal Service Order* at 335-36 (emphasis added).

But instead of then structuring the program at the outset as a program with mandatory funding obligations that sprang from the statute itself, the FCC made the determination to establish a $400 million cap on RHC funding. It did so not because it was directed to by Congress, or because the initial Joint Board suggested a cap, but instead to "be specific, predictable, and sufficient." *FCC Universal Service Order* at 365.

FCC lacked the authority, under the statute, to create this arbitrary cap. The legality of the cap has not yet been litigated because the funding within the so-called cap has, until 2016, kept pace with demand for funding. This is notwithstanding the fact that if the initial $400 million cap had been increased in pace with inflation, it should now (at a minimum) be funded at $609,405,607. Nonetheless, the FCC has kept the cap in place, despite the mandate of the statute.

Even when it established the cap, the FCC still intended the RHC to provide full funding. In the FCC Universal Service Order, the FCC found that the cap was only intended to provide a specific amount to Congress, not to require a pro rata formula for distribution. The FCC stated "[w]e estimate that the **maximum** cost of providing services eligible for support under section 254(h)(1)(A) is $366 million, if **all eligible health care providers** obtain the **maximum** amount of supported services to which they are **entitled**." *FCC Universal Service Order* at 366 (emphasis added).

Funding for broadband-enabled health care is needed today more than ever, and the $400 million cap established 20 years ago was not established consistent with the statutory language mandating full RHC funding. The USAC now administers almost $10 billion annually in the Universal Service Fund.[3] The FCC cap, in shorting tribes and Alaska Native organizations such as CATG, has violated the agency's own tribal Policy Statement as well as the trust responsibility of the federal government to provide health care to American Indians/Alaska Natives. 2016 has shown that this arbitrary cap is now not only no longer sufficient to meet burgeoning demand, but the inclusion of a new class of provider eligible to receive funding – skilled nursing facilities – beginning in 2017 will place additional demands on funding and further erode CATG programs and services. Lives are truly at stake.

[3] http://www.usac.org/about/default.aspx.

Conclusion

Therefore, for the foregoing reasons, CATG requests that this appeal be granted and that the RHC Division commit full funding for all of the attached FCLs in the amount that is in dispute due to the pro rata formula $8,434.74.

Respectfully Submitted,

Geoffrey D. Strommer by SDO

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On behalf of
Council of Athabascan Tribal Governments

Government-to-Government Consultation
Alaska Native Health Board, the
Bristol Bay Area Health Corporation, and the
Federal Communications Commission
Mohegan Sun Resort (Penobscot Room)
Wednesday, June 14th at 10:40AM-11:00AM

BACKGROUND - BBAHC

- The Bristol Bay Area Health Corporation (BBAHC) was created in 1973 to provide health care services to the Alaska Native people of Southwest Alaska.

- We began operating and managing the Kanakanak Hospital and the Bristol Bay Service Unit for the Indian Health Service (IHS) in 1980, and were the first tribal organization to do so under the Indian Self-Determination and Education Assistance Act (ISDEAA).

- BBAHC is now responsible for and successfully providing and promoting health care to 28 Alaska Native Villages.

- For many years the BBAHC has been a recipient of the Rural Health Care (RHC) Universal Service Support, specifically under the Telecommunications Program.

- These program funds have been key for our organization to deploy and use telehealth tools supporting high speed broadband that has become a platform for 21st Century Electronic Health Records that can be shared securely with other medical providers to directly improve patient care throughout Alaska.

- In addition, the support helps us to alleviate the high costs of transportation associated with travel to and from rural Alaska. The proposal by the FCC to pro-rate subsidies for Internet service is a potentially devastating development that will undermine BBAHC's ability to provide adequate health care services to our tribal communities.

- On June 12, 2017, BBAHC (along with Maniilaq Association, Aleutian Pribilof Islands Association, Council of Athabascan Tribal Governments and Norton Sound Health Corporation) filed an appeal with the USAC on the application of the pro-rated cuts to BBAHC funding.

- The result in lost funding to BBAHC and its service provider in 2016 alone, from the 7.5% cut, was over $1.7 million.

BACKGROUND

- Chairman Pai and FCC Commissioners and staff.

- Thank you for your recent support of the Rural Health Care Program and your recognition in the Senate Commerce Committee FCC Oversight hearing that broadband telemedicine is a critical component of addressing the health care needs in Alaska.

- Thank you also Chairman Pai for your visit to rural Alaska five years ago. We appreciate that you are familiar with the high connectivity costs and understand the significant problem faced by healthcare providers in Alaska.

- We are asking for your support to ensure that Alaskans continue to have access to affordable broadband telehealth services in rural and tribal communities.

- We ask that you take steps to ensure both the near and long-term viability of the Rural Health Care Program to meet the increased demand for telemedicine services both in Alaska and across the nation.

- As you know in many regions of Alaska rural providers rely on satellite transmission circuits.

- BBAHC serves a vast area covering 28 tribal villages and currently has a USAC Internet subsidy to allow the organization to connect through satellite.

- Primary and specialty clinic support is located in Anchorage, often times hundreds of air miles away from a rural area.

- Telemedicine and access to high speed Internet connectivity has dramatically improved access to care by accelerating diagnosis and treatment, avoid unnecessary medivacs, and expanding local treatment options.

- It has also helped reduce Medicaid costs and has greatly improved medication management.

- Medical records are now electronic which allows doctors to see a patient's records in remote areas that in tern reduces hospital re-admittance, increases patient safety, and brings a sense of security to all who manage patient care.

- Connectivity is the lifeline for health services in our state where a majority or rural communities are not connected to a road system.

IMPACTS

- The current $400 million Rural Health Care Universal Service Support budget remains at 1997 levels, despite inflation, advances in technology, and increased demand for services.

- Congress did not mandate this cap in the authorizing statute, so FCC can revisit it, particularly since in 2017 additional types of health care providers will be eligible to draw on these funds for the first time.

- When USAC announced that it exceeded the funding cap for FY16 and eligible applicants that filed during the September-November 2016 filing window would receive a pro-rated percentage of the qualifying funding at a reduction of 7.5%, it was unclear how significant that impact would be. It is devastating, cutting over $1.7 million to BBAHC and its internet service provider in 2016 alone

- Increased costs associated with pro-rated subsidies are substantial and have a disproportionate impact on rural Alaska healthcare providers.

- BBAHC will likely have to reduce or interrupt the broadband services currently used that allow us to provide healthcare given the cuts in funding. The outcome is likely to be a substantial reduction in patient health care services, which could adversely affect the lives of thousands of Alaskans.

- BBAHC is very concerned that if funding requests are reduced (pro-rated) or denied entirely, the continuity of our existing and new rural health care services will be put in immediate jeopardy.

- Our health organization currently receives a USAC subsidy that offsets our Internet expenses so we are able to connect through satellite.

- **Our current payment is $94,000 per ~~month~~** Year or $7,800/month **. Under the FCC proposal, going forward, our payments would increase to $175,000 per month. In other words, an annual increase of $2.72 million, which is even greater than the 2016 amount currently under appeal.** For 2017 this will amount to an 1800% cost increase. FY17 will likely be much higher than 1800%.

- This is in addition to the portion of the cost of services that we are already responsible for paying under the rules of the rural health care support mechanism.

- This increase was not budgeted or anticipated and as a result we will have no choice but to cancel future Internet service contracts.

- BBAHC is not able to pay for such a substantial increase in Internet connectivity. This increase will affect not only our health organization, but would negatively impact and potentially cripple the entire Alaska Tribal Health System in the State of Alaska.

- Our facilities cannot raise service rates to compensate for the increase in costs for due to the proration that is proposed to compensate for this increase in costs for our network circuits.

- This change will directly impact patient services by cuts to personnel, programs, direct health services, and could result in closing health clinics.

NEXT STEPS & REQUEST

- As the FCC considers its options to try and resolve the problem, please note that a regulatory change would be needed to increase the $400 million cap or to change the current pro-rating formula and that could take a significant amount of time and such a change would not be completed in time to fix the issue for FY16 or FY17.

- Our health organization is happy to share our data with the FCC to help you determine what options might be available and most appropriate to address this critical and immediate problem.

- We ask that you take steps to ensure both the near and long-term viability of the Rural Health Care Program to meet the increased demand for telemedicine services both in Alaska and across the country.

- We respectfully request that the FCC increase the budget for the rural health care support mechanisms to reflect inflation over the past two decades, as well as increased technology and telecommunications demands due to HIPAA legal obligations, advances in telemedicine capabilities, changes in patient expectations and standards of care, and new demands from skilled nursing facilities.

- We believe that this request is aligned with the President Trump's priority to improve infrastructure in America.

- We would appreciate the FCC opening up a comment period on this issue to hear from Tribes as well as internet providers who support getting rid of the funding cap.

- In addition, please consider implementing an inflation adjustment mechanism for the future, and short-term measures to restore qualifying funding requests filed Sept. 1 - Nov. 30, 2016 to 100%.

- We also ask that you please be aware of the pending USAC dispute over the pro-rated formula and that the FCC considers the possibility of a waiver of the FCC rule for FY16 that would enable an Alaska specific-fix.